• S O H M A •
INTEGRATIVE HEALTH CENTER

Consent for Photography

I consent to have my (or child or an individual to whom I provide guardianship) image to be taken by the staff at Sohma Integrative Health Center as described below.

I understand that my (or child or an individual to whom I provide guardianship) photographs, videotapes, digital, and other images may be recorded to document and assist with my care and the payment of my bill (or child or an individual to whom I provide guardianship). These images may be used to assist in the education of students and residents within the institution. I understand that SOHMA Integrative Health Center will own these images, but that I will be allowed access to view them or to obtain copies of them at any time and with reasonable cost. Other than for treatment, education, and payment purposes, images that identify me (or child or an individual to whom I provide guardianship) will be released and/or used outside the organization only upon written authorization from me or the patient representative.

If the images are to be taken for any purpose other than for treatment, education, or payment purposes, the purpose(s) must be stated:

___ I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

___ I release and hold harmless the SOHMA Integrative Health Center Physicians, its staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the photograph or other image.

By signing below, I am indicating that I have read and understand the “Consent for Photography” form. I am either the patient or have the authority to give consent for the patient. My questions regarding this consent have been answered.

_____ _____

Patient’s Name (Printed) Date

_____

Patient or Guardian’s Signature